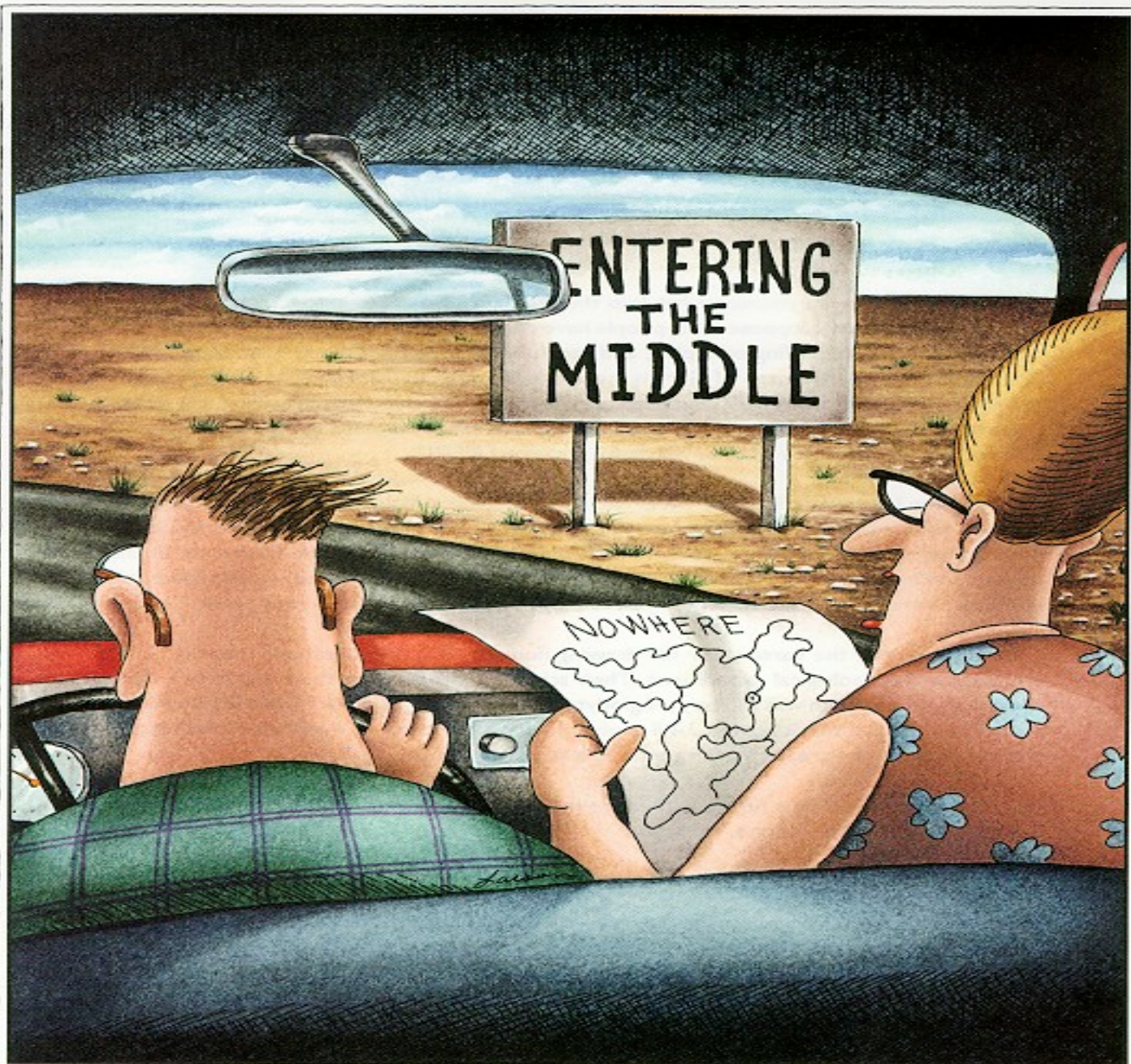


Fluid Vulnerability Theory and Suicide Risk Assessment

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"Well, this is just going from bad to worse."

Assessment Versus Prediction

- Expectation for *prediction* exists
- Assessment is the integration of multiple sources of data into a scientifically informed clinical decision
- Efforts to *predict* suicide in individual cases have consistently failed due to its low base rate, limited knowledge base
- We can identify when someone enters the *suicide zone* (Litman)

Assessment Versus Prediction (continued)

- Recognizing the *suicide zone* (assessment) and appropriate response (treatment)
- Assessment *explains* and *estimates* the client's suicidality---does not predict the outcome
- Provides a *treatment map* that identifies areas of risk for treatment and ongoing monitoring



Front porch forecasters

and Vulnerability Theory and Suicide Risk Assessment

■ Fundamental Assumptions:

- Baseline risk varies from individual to individual
- Baseline risk is determined by *static* factors
- Baseline risk is higher for multiple attempters (2 or more attempts)
 - more severe, enduring crises w/ precipitant
 - more frequent, severe, enduring crises w/o precipitant
 - more frequent instrumental behaviors/acts

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- Risk is elevated by *aggravating* factors
 - Severity of risk is dependent on baseline level and severity of aggravating factors

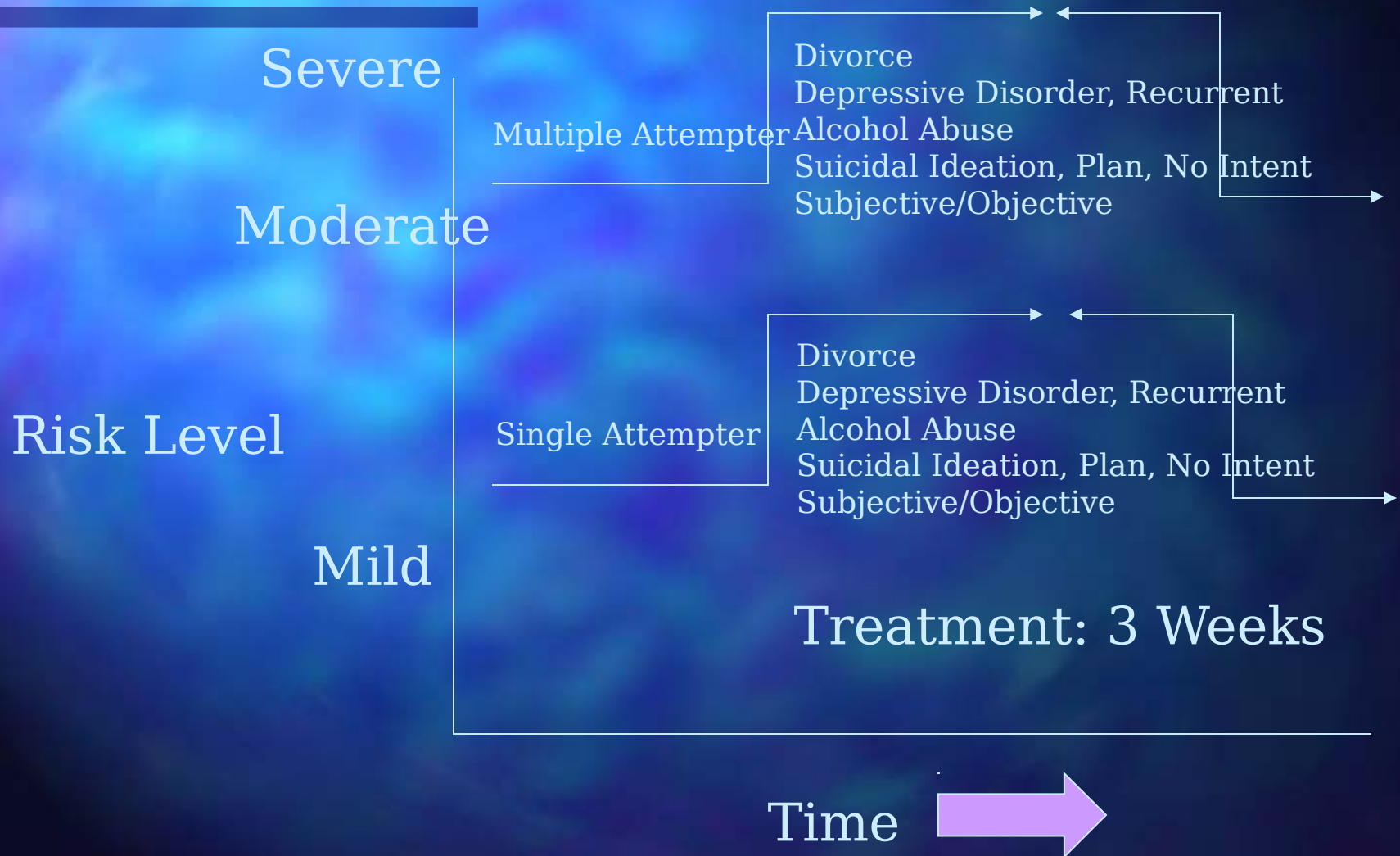
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- Risk is elevated by aggravating factors for limited periods of time
 - hours, days, weeks
 - Risk resolves when *aggravating* factors effectively targeted
 - Risk returns to baseline level only
 - Modifying baseline risk requires long-term treatment not just symptom resolution (Axis I)

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- Risk assessment is complicated by the inconsistent use of terminology
 - Risk is reduced by protective factors
 - Multiple attempters have fewer available protective factors (support, interpersonal resources, coping/problem-solving skills, cognitive, treatment hx)

Risk Quotient

- Risk = Static Factors + Aggravating Factors
- Protective Factors

Graphic Example



Practical Implications

- Risk: high risk can be enduring, resistant to short-term interventions
- Treatment: short-term, long-term targets
- Liability: limited predictability, control
- Patient responsibility: significant for crisis management, treatment

Definitional Issues

Differentiated on three features:

- Intent (i.e., subjective versus objective)
- Evidence of self-infliction
- Outcome (i.e., injury, no injury, death)

Advantages

- Remove pejorative language: gestures
- Improve consistency of documentation
- Improve communication between clinicians
- Improve accuracy of risk assessments
- Improve clinical decision making
- Improve treatment outcomes

Intent: Subjective vs. Objective

- Subjective: *stated intent*
- Objective markers of intent: lethal method, preparation (letter writing, financial records, giving away possessions), prior attempts with serious injury, efforts to prevent discovery/rescue, help seeking behavior after an attempt

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- Use of subjective ratings
 - Use of *intent scales* to assist in developing clarity

Example of Objective Markers of Intent

- 28 y/o African-American male hung himself in the closet (highly lethal method), waited till his wife and child left, prepared a financial and insurance packet, made no effort to seek help, was only discovered because his wife *forgot something at the house* and returned

Terminology

- Suicide attempt with injuries
 - non-fatal injury, intent, extent of injuries
- Suicide attempt without injuries
 - potentially self-injurious behavior, intent
- Instrumental suicide related behavior
 - potentially self-injurious behavior, motivation other than death, with/without injuries
- Suicide Threat
 - interpersonal action, verbal or nonverbal, stopping short of a directly self-harmful act

Risk Categories: Static

- Predisposition to Suicidality
 - prior suicidality, attempts, ideation
 - frequency, context, perceived lethality, outcome, stated intent, rescue opportunity, preparatory behaviors (psychological/practical), help seeking behaviors
 - psychiatric hx, diagnosis, treatment hx, response, compliance
 - abuse hx, sexual, physical, emotional

■ Primary Distinctions:

- Multiple attempters vs. single attempters or ideators
- Psychotic vs. non-psychotic
- Presence vs. absence of substance abuse

Risk Categories: Aggravating

- Precipitant/Stressors
- Symptoms
 - type, breadth, severity, duration
 - associated cognitive disruption, mental status impairment
- Hopelessness
 - severity, duration, source(s)

■ Nature of Suicidal Thinking

- Ideation: frequency, intensity/severity, duration, specificity (plans), availability/accessibility, active behaviors, intent (subj. vs. obj.), deterrents

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- Impulsivity/Self-Control
 - objective vs. subjective
 - duration, severity, source

Risk Categories: Protective

■ Protective Factors

- social support, available and accessible
 - previous crises
- coping/problem-solving skills
 - previous crisis management
- cognitive flexibility
- treatment compliance hx critical
 - investment/commitment to treatment

Risk Classification

- Acute Risk (1 or fewer previous attempts)
 - Mild
 - Moderate
 - Severe (objective markers of intent, none stated)
 - Extreme (objective and subjective intent)
- Chronic Risk (2 or more previous attempts)
 - with/without acute exacerbation

■ Chronic risk

- document chronic risk variables
 - prior suicidal behavior
 - chronic psychiatric disturbance
 - treatment compliance history
- document nature of acute exacerbation
 - specific symptoms, precipitant
 - lack of clear precipitant----internal trigger(s)
 - open vs. closed markers
- treat acute exacerbation during period of risk

Risk and Response

■ Severe, Extreme

- immediate psychiatric evaluation
- accompanied and monitored

■ Moderate

- increase frequency, duration of sessions
- periodic consideration of need for hospitalization
- involvement of family

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- Reevaluation of treatment goals
 - 24-hour availability of ER services
 - frequent reevaluation of suicide risk
 - consideration of medication for symptom relief/stabilization
 - Use of telephone monitoring
 - consultation
 - frequent input from family members

Risk Assessment: Process

- Interpersonal variables important:
 - direct, unambiguous language
 - eye contact
 - specific questions
 - repetitive questions (method, plan)
 - collaborative decision making
 - role of hierarchical questioning
 - acknowledge resistance

The Role of Chronicity and Time

- Risk periods are not consistently defined in the literature, usually very long periods of time
- What predicts acute risk is not well defined
- Chronic suicidality, *suicidal careers*, complicates estimates of risk
- Distinguish between acute risk and those at chronic risk (multiple attempters) with or without acute exacerbation

Clinical Example

- Mr. B., a 19 y/o college student reported being depressed, noting symptoms adequate for diagnosis. He'd been struggling with chronic arthritis and stated that the transition to college *had not gone well*, noting that *it's hard not being able to do the things you should*. He admitted to some limited writing about suicide and also noted *jotting down* who would get *his stuff* if he died.

Clinical Example (continued)

- He had become progressively more isolated over the last few weeks and had engaged in episodic alcohol abuse. He described himself as *lonely*, noting that he had few friends. He stated that he has thought about *shooting himself*, did not have access to a weapon, but *knew where to get one*. There were no prior attempts reported and no prior mental health care.

Differentiating Between Crises and Emergencies

- **Crisis:** a serious disruption of a person's baseline level of functioning such that his or her usual coping mechanisms are inadequate to restore equilibrium
- **Emergency:** occurs when a state of mind is reached in which there is imminent risk that he or she will do something (or fail to) that will result in serious harm to self/others unless there is immediate intervention

Implications of Using Term *Emergency*

- There is a ***legal duty of care*** (ethical and legal obligation to provide care) during *emergencies*
- An ***essential*** element of this duty is the clinician-client relationship which can be established in ER, phone calls.
- Duty is to use *available and reasonable means* to prevent harm

Crisis Phone Calls

■ Implications

- Creates client-therapist relationship
- Results in obligation to respond/manage/treat

No-Suicide Contracts

- Have limited value and meaning
- No empirical support
- Pose a potential liability
- More a reflection of clinician anxiety and lack of control
- Not actually a therapeutic intervention
- Hidden messages
 - blame, control, *open* communication

Why do we use no-suicide contracts?

- Fear of lawsuits
- Clinician attitudes, believed successful by most clinicians
- Interpersonal and unconscious factors
 - control
 - predictability

Alternatives

- *Commitment to treatment statement*
- *Crisis response plan*

Commitment to Treatment Statement

- *I agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment including:*
- *attending sessions (or letting you know when I can't make it)*
- *voicing my opinions, thoughts, and feeling honestly and openly, whether negative or positive*

CTS (continued)

- *being actively involved **during** sessions*
- *completing homework assignments*
- *experimenting with new behaviors and new ways of doing things*
- *taking medication as prescribed*
- *implementing my crisis response plan.*

CTS (continued)

- *I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. If it's not working, I'll discuss it with my therapist. In short, I agree to make a **commitment to living***

Crisis Response Plan (CRP) Components

- Define *crisis*
- Identify trigger(s) and associated thoughts, feelings (suicidal belief system)
- Productive response to deactivate suicidal mode
- If not successful, access emergency care and assistance in manner that facilitates skill development

Crisis Response Plan

- *When thinking about suicide, I agree to do the following:*
- *When I find myself making plans to suicide*
 1. *Complete a STR and try to identify specifically what's upsetting me*
 2. *Write out and review more reasonable responses to my suicidal thoughts, including thoughts about myself, others, and the future*
 3. *Review all the conclusions I've come to in my treatment log*
 4. *Do things that help me feel better for about 30 minutes, including taking a bath, listening to music, and going for a walk*
 5. *Repeat all of the above*
 6. *If the thoughts continue, get specific, and I find myself preparing to do something, I call the emergency number XXX-XXXX*
 7. *If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room*

Crisis Response Plan Pointers

- Be specific
 - when to use, steps to take, where to go, what numbers to call
- Be concrete
- Ensure safety, remove access, availability
- Make it accessible
 - put on a card, can be carried in a wallet or purse
- Practice, role play
- Periodically review and update
- Use of STR

Crisis Services and Availability

- Clear crisis management plan
 - integrated into informed consent statement
 - use of crisis cards
- Accessible referral sources
 - clarity of identifying those requiring long-term care
 - out of center referrals following crisis stabilization

Suicide Assessment Measures

- Poor predictive power and low base rate phenomenon
- Ambiguous data and the nature of suicidal ambivalence: variable depending on instrument (MMPI, Rorschach, BSSI, MSSSI, BHS)
- Empirical research is limited: **very few** studies regarding predictive validity (e.g ., BSSI, BHS)

Suicide Assessment Measures: Problems

- Little predictive validity
- Limited settings for development, application: psychiatric patients, college students, few used in ER's, primary care settings
- Most target children, adolescents, young adults, few for elderly, none address potential differences with minority populations

Suicide Assessment Measures: Problems

- Potential differences between self-report and clinician-rated scales---recommend use of both
- Clinician's rate risk as more extreme in comparison to self-report
- Issue of liability in primary care settings---availability of immediate intervention

Supervision/Consultation

- Supervision program
 - definitional issues
 - consistency of risk assessment
 - individual attitudes, beliefs, countertransference management and understanding
 - management of client emotional abuse
- Case conferences
- Morbidity/mortality committee review